

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022180

STATE FILE NUMBER

FILED JUL 8 1959 Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 184

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Marion</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Marion</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hannibal</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Hannibal</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Levering Hospital</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>2618 Bird Street</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ION</b> Middle <b>THOMAS</b> Last <b>WALLER</b>			4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 25, 1883</b>	9. AGE (In years last birthday) <b>76</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Real Estate</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	11. BIRTHPLACE (City and state or country) <b>Macon County Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Richard Waller</b>		13b. MOTHER'S MAIDEN NAME <b>Georgia Meyer</b>		14. NAME OF HUSBAND OR WIFE <b>Sarah S. Goodrich Waller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>190 09 8078</b>	17. INFORMANT Address <b>Mrs. L.T. Waller Hannibal Missouri</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aortic insufficiency</b> DUE TO (b) <b>Arteriosclerotic Vascular disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4 2 1 1</b>					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <b>1959</b> to <b>26 June 1959</b> and last saw her/him alive on <b>26 June 1959</b> Death occurred at <b>7:20 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Walter Norman MD</b>			22b. ADDRESS <b>Hannibal Mo.</b>		22c. DATE SIGNED <b>6/27/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6/29/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet</b>		23d. LOCATION (City, town, or county) (State) <b>Hannibal Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>W. C. Good Smith Hannibal Missouri</b>			25. DATE RECD. BY LOCAL REG. <b>7-1-1959</b>	26. REGISTRAR'S SIGNATURE <b>Dr. E. M. Luckey &amp; C. Fisher</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

DA FILED JUL 7 1998

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *John S. [Signature]* .....

Licensed Embalmer No. 4540 .....

P. O. Address Hannibal Missouri .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.